

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045702

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11211

FILED NOV 22 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Ferguson</b>	
Length of stay in 1b <b>6 days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>338 S. Marguerite</b>	
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>A.</b> Last <b>Lange</b>		4. DATE OF DEATH Month <b>11</b> Day <b>10</b> Year <b>63</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/2/97</b>
9. AGE (last birthday) <b>66</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clothing Cutter-Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Hugo W. Lange</b>		13b. MOTHER'S MAIDEN NAME <b>Bertha Kaemmerer</b>	
14. NAME OF HUSBAND OR WIFE <b>Elizabeth Lange</b>		Address <b>338 S. Marguerite</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>330X</b>	
17. INFORMANT <b>Mrs. Elizabeth Lange</b>		Interval between onset and death <b>5 days</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> DUE TO (b) <b>Ruptured cerebral artery for aneurysm 5 days</b> DUE TO (c) <b>Anterior communicating artery aneurysm 4 weeks</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>330X</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>8/12/57</b> to <b>11/10/63</b> and last saw him alive on <b>11/10/63</b> Death occurred at <b>11/10/63 5:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Frank S. Gentry M.D.</b>		22b. ADDRESS <b>1116 North Ferguson St. St. Louis, Mo.</b>	
22c. DATE SIGNED <b>11/2/63</b>		22d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>11/13/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>	
24. FUNERAL DIRECTOR <b>Drehmann-Harral</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 13 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Robert Smith, M.D.</b>			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

Dr. Jos. D. Judy  
111 Church St.  
Ja. 1-0709

Hrs. 11 AM - 2 PM  
4:30 (for evening)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Warren A. Carver*

Licensed Embalmer No.

*3534*

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.